





**APPLICATION FOR DISABILITY INSURANCE**  
**PETERSEN INTERNATIONAL UNDERWRITERS**  
*Lloyd's Coverholder*

**PART I.**

**FINANCIAL INFORMATION**

11. What was your gross income less business expenses, but before taxes from your profession last year? US\$ \_\_\_\_\_
12. What was "other income" last year from dividends, interest, rents, royalties, estates and trusts, etc.? (Circle items.) US\$ \_\_\_\_\_
13. What was contributed to IRA, HR10, qualified pension or profit-sharing plan? Is this included in #11?  Yes  No US\$ \_\_\_\_\_

*Please indicate the type of coverage and the amount of coverage that you are applying for.*

14.  Personal  Overhead Expense  Key Person  Loan Indemnification  Buy/Sell  Other  \_\_\_\_\_

**15. Section I — Monthly Benefits (if applicable)**

Monthly Benefit requested: \_\_\_\_\_ US\$  
 Elimination Period requested: \_\_\_\_\_ Days  
 Benefit Period requested: \_\_\_\_\_ Months

**Section I - Optional Riders:**

- Residual  
 COLA  
 Prime Flex (Loan Indemnification Only)  
 Salary Replacement Rider (Overhead Expense Only)  
 Business Revenue Replacement Rider (Key Person Only)

**16. Section II — Lump Sum Benefit (if applicable)**

Principal Sum requested: \_\_\_\_\_ US\$  
 Elimination Period requested: \_\_\_\_\_ Months

**ADDITIONAL POLICY INFORMATION**

17. Does your employer provide disability benefits or salary continuation benefits?  Yes  No
18. Please list all disability insurance (including individual, group, mortgage, and credit plans) for which you are applying, have in force, or are reinstating. If none, please indicate "None".  None

Insurer	Issue Date	Personal DI Monthly Benefit	Business Overhead Monthly Benefit	Buy/Sell Disability	Other Disability

19. Are you terminating any existing policies listed above in order to qualify for the coverage now being applied for?  Yes  No  
 If "Yes" please indicate the coverage that is to be terminated. \_\_\_\_\_

**PLEASE INITIAL THE FOLLOWING**

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application. \_\_\_\_\_





**APPLICATION FOR DISABILITY INSURANCE**  
**PETERSEN INTERNATIONAL UNDERWRITERS**  
*Lloyd's Coverholder*

**PART II.**

**MEDICAL INFORMATION CONTINUED**

*If "Yes" is answered for any of the following questions please provide full details in the space below.  
 If there is not sufficient space, please attach your answers on a separate sheet.*

- 23. Have you used tobacco at any time within the last three years?  Yes  No
- 24. Has your weight increased or decreased more than 10 pounds within the last year?  Yes  No
- 25. Are you now taking/using prescription medication and/or nonprescription medication?  Yes  No
- 26. In the last 60 days, have you taken any medicines which are not listed in #25?  Yes  No
- 27. Within the last 5 years have you had or been advised to have a surgical operation or hospitalization?  Yes  No
- 28. Have you ever received or requested benefits or payments because of an injury or illness or disability?  Yes  No
- 29. Within the last 5 years have you had x-rays, electrocardiograms, blood studies or other diagnostic tests?  Yes  No
- 30. Have you ever received treatment or joined an organization for alcoholism or drug dependence?  Yes  No
- 31. Have you or a parent, brother or sister ever had diabetes, high blood pressure, heart disease or mental illness?  Yes  No
- 32. Within the last 5 years have you had any procedures, examination or tests recommended which have not been completed?  Yes  No
- 33. Except as prescribed by a physician, have you ever used heroin, cocaine, codeine, barbiturates, amphetamines, hallucinogens, or other drugs?  Yes  No

Question #	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery	Doctors & Hospitals with Addresses

( Use additional sheets if needed)

- 34. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application?  Yes  No - If No, please provide details: \_\_\_\_\_



**IT IS UNDERSTOOD AND AGREED:**

1. that all answers to the questions on this application, to the best of my knowledge and belief, are complete and true,
2. that all answers on this application shall form the basis of the issuance of any coverage hereunder,
3. that in the event of any fraud, misstatement, concealment, or failure to disclose information in response to any question on this application, whether intentional or inadvertent, any insurance coverage issued based upon this application may become void, and no benefits shall be payable, and
4. the insurance hereunder applied for shall take effect on the date set forth on the certificate, if issued, provided the first premium and all requirements are received within 31 days of the effective date and there have been no changes to any questions on this application between the date of application and the effective date of the certificate.
5. I have read or had read to me and understand each of the questions and statements on this entire application.
6. No one has prevented me from spending as much time as I felt was necessary to understand this application.

\_\_\_\_\_  
 Signature of Applicant                      Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Policy Owner - (if not Applicant)                      Date: \_\_\_\_\_



**PETERSEN INTERNATIONAL UNDERWRITERS**  
23929 Valencia Boulevard, Suite 215, Valencia, California 91355  
(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604  
Website: <http://www.piu.org> E-Mail: [piu@piu.org](mailto:piu@piu.org)

**AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION**  
**This Authorization complies with the HIPAA Privacy Rule**

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I authorize** all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/representative including, but not limited to: Secure Image Solutions, for the purpose of insurance underwriting or claims administration.

**For purposes of this authorization**, medical records shall include all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, information and/or HIV Tests/Test Results, and any other pertinent medical information.

**I understand and agree** that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above. I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

**I understand** that I may refuse to sign this authorization and that such refusal to sign will not be a condition to affect the ability of the Applicant to obtain treatment. I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters  
23929 Valencia Boulevard, Suite 215  
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization. This Authorization will expire 2 years after the date the Authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*Signature of Legal Representative (if other than Proposed Insured/Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

*\*If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.*



# LIFE & DISABILITY DIVISION

## Confidential Financial Statement

Proposed Insured: FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_

The following financial disclosure is made for the purpose of establishing insurability in connection with a pending application on myself. This is furnished as a true and accurate statement of my financial condition as of:

\_\_\_\_\_, 20\_\_

	Column (A) CURRENT YTD 20__	Column (B) LAST YEAR 20__	Column (C) TWO YEARS AGO 20__
<b>I. ANNUAL INCOME</b> from occupation or profession			
Net income (after business expenses, before taxes) (Include nonpassive income from Schedule K-1)	US\$ _____	US\$ _____	US\$ _____
Commission Income	US\$ _____	US\$ _____	US\$ _____
Bonuses	US\$ _____	US\$ _____	US\$ _____
Pension & Profit Sharing Contributions	US\$ _____	US\$ _____	US\$ _____
Royalty Income	US\$ _____	US\$ _____	US\$ _____
<b>II. OTHER INCOME</b>			
Dividends and Interest	US\$ _____	US\$ _____	US\$ _____
Net Real Estate Income before Depreciation (Net income after expenses)	US\$ _____	US\$ _____	US\$ _____
Passive income from Schedule K-1	US\$ _____	US\$ _____	US\$ _____
Other (Please specify) _____	US\$ _____	US\$ _____	US\$ _____
_____	US\$ _____	US\$ _____	US\$ _____
<b>III. TOTAL CURRENT NET WORTH</b> (Please itemize below)			
Cash, Savings, Stocks, Bonds	US\$ _____		US\$ _____
Personal Property (e.g. furnishings, jewelry, car, boat, etc.)	US\$ _____		US\$ _____
Personal Residence (fair market value less mortgages, loans)	US\$ _____		US\$ _____
Other Real Estate (fair market value less mortgages, loans)	US\$ _____		US\$ _____
Business Interest (show fair market value less mortgages, loans)	US\$ _____		US\$ _____
Other (Please specify) _____	US\$ _____		US\$ _____
_____	US\$ _____		US\$ _____
<b>IV. ADDITIONAL CLARIFYING INFORMATION</b>			
<b>V. ARE YOU A PARTY TO ANY LEGAL PROCEEDING AT THIS TIME?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", furnish all details.			

I hereby certify that the above answers are true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured

### PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Blvd., Suite 215 • Valencia, California 91355  
Tel (661) 254-0006 - Fax (661) 254-0604 - (800) 345-8816

[www.piu.org](http://www.piu.org) [piu@piu.org](mailto:piu@piu.org)